Annual Report to

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

on

Deaths Reported and Facility Compliance with Restraints and Seclusion

as originally required by SL 2000-129, House Bill 1520, Sections 3(b), 5(b) and 6(b)
and as amended by SL 2003-58, House Bill 80, Sections 1-4

Submitted by

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
and
Division of Facility Services

October 1, 2006

Deaths Reported and Facility Compliance With Restraints And Seclusion

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INTRODUCTION

Section 3(b), 5(b) and 6(b) of Session Law 2000-129 (HB 1520), as amended by Sections 1-4 of Session Law 2003-58 (HB 80), requires the Department of Health and Human Services to report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services on the following for the immediately preceding fiscal year:

- The total number of facilities that reported deaths under G.S. 122C-31, G.S. 131D-10.6, and G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to these statutes, and the number found by the investigation to be related to the use of restraint or seclusion.
- The level of compliance of certain facilities with applicable State and federal laws, rules, and regulations governing the use of restraints and seclusion. The information shall include areas of highest and lowest levels of compliance.

Outlined in the succeeding pages is a compilation of the data provided by these facilities in addition to deficiency information from monitoring reports, surveys and investigations conducted by Department staff. **This data covers the period of July 1, 2005 through June 30, 2006.**

DEATHS REPORTED

Session Law 2000-129 amended G.S. 122C-31, 131D-10.6B and 131D-34.1 by requiring certain facilities to notify the Department of Health and Human Services of any death of a consumer:

- Occurring within seven days of use of physical restraint or physical hold; or
- Resulting from violence, accident, suicide or homicide.

10A NCAC 26C Section .0300 implement the death reporting requirements of these laws and provide specific instructions to facilities for reporting deaths.

- **Facilities licensed** in accordance with G.S. 122C, Article 2, **State facilities** operating in accordance with G.S. 122C Article 4, Part 5 and **inpatient psychiatric units** of hospitals licensed under G.S. 131E shall report client deaths to the **Division of Facility Services**.
- **Facilities not licensed** in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5 shall report client deaths to the **Division of Mental Health, Developmental Disabilities, and Substance Abuse Services**.

All deaths reported to the Department are screened to determine if an investigation is warranted. The primary purpose of the screening and any subsequent investigation is to determine if the facility was culpable in the consumer's death. For purposes of this report, the outcome of the investigation is limited to whether the death occurred as a result of restraint, physical hold, or seclusion.

The following seven tables depict each facility that reported one or more deaths for the time period beginning July 1, 2005 and ending June 30, 2006. The first five tables provide information about deaths reported by private facilities. The last two tables provide information about deaths reported by state facilities. Each table identifies the number of deaths reported and screened, deaths investigated and the number found by the investigation to be related to the facility's use of physical restraint, physical hold, or seclusion. If a facility is not listed, a death was not reported to the Department.

DEATHS REPORTED BY PRIVATE FACILITIES

The first five tables provide data submitted by private facilities regarding deaths that were subject to the reporting requirements in G.S. 122C-31, 131D-10.6B and 131D-34.1, namely deaths that occurred within seven days of restraint, physical hold, or seclusion, or that were the result of violence, accident, suicide or homicide. These tables do not include deaths that were voluntarily reported to the Department that were the result of other causes. It should be noted that all deaths that were reported were screened and investigated when circumstances warranted it. Summary information about other deaths that were voluntarily reported to the Department are provided after each table.

Private Facilities: Licensed Assisted Living Facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Investigated and Death was related to Restraint/Hold[3]
Alexander	Belle's View Adult Care	1	0	
Catawba	Austin Adult Care	1	1	
	Carillon Assisted Living	1	1	
Craven	Christian Care of New Bern	1	0	
Davidson	The Oaks of Thomasville	1	0	
Davie	Davie Place	1	1	
Durham	Eno Pointe Assisted Living	1	0	
	Meadows of Oak Grove	1	1	
Forsyth	Clemmons Village 1	1	1	
	Reynolds House	1	0	
	The Homestead	1	1	
	Woodland Place	1	1	
Gaston	Gaston Manor	1	0	
	South Haven Assisted Living	1	0	
Guilford	Oak Hill Rest Home	1	1	
Hertford	Pinewood Manor	1	0	
Iredell	Heritage Place Adult Living Center	1	1	
	Olin Village	1	0	
	Summit Place of Mooresville	1	0	
Martin	Vintage Inn	3	0	
McDowell	McDowell House	1	0	
Montgomery	Starmont Assisted Living	2	0	
Moore	Elmcroft	1	0	
Onslow	Meadows of Onslow Pines	1	0	
Pitt	Meadows of Greenville	2	0	
Rowan	Carillon Assisted Living	1	0	
	Meadows Retirement Center	2	0	
Scotland	Meadows of Laurinburg	1	0	

Private Facilities: Licensed Assisted Living Facilities[1] (Continued)

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Investigated and Death was related to Restraint/Hold[3]
Stokes	Overby's Rest Home	1	0	
	Priddy Manor Assisted Living	1	0	
Wake	Pine Tree Villa	1	1	
Watauga	Highland Hall Assisted Living	1	0	
Wilson	Barnes Family Care#2/Lois House	1	0	
	Diversicare Assisted Living	1	0	
Total		**39**	**10**	**0**

NOTES:

1. There were 1,308 Licensed Assisted Living Facilities with a total of 40,241 of beds during the report period.
2. For licensed assisted living facilities, the investigation is initiated by a referral of the death report to the Adult Care Licensure Section of DFS and the County Department of Social Services by the DFS Complaint Intake Unit after screening for compliance issues.
3. Shading in the last column, titled "# Investigated and Death was related to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not related to restraint or physical hold.

A number of licensed assisted living facilities voluntarily reported deaths that were not subject to G.S. 131D-34.1. For the period beginning July 1, 2005 and ending June 30, 2006, 30 facilities reported 36 such deaths. All of these deaths were screened. None required investigation. None of these deaths were related to restraint or hold. These numbers were not included in the above table.

Private Facilities: Group Homes, Outpatient and Day Treatment facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was related to Restraint/Hold[2]
Anson	Sandhills Center for MH/DD/SAS	1	0	
Caldwell	New Horizons P.S.R.	1	0	
	VOCA-Laurel	1	0	
Guilford	ADS/Washington	2	1	
	Alcohol and Drug Services	1	0	
	Bramlet Place	1	1	
	The Guilford Center-Highpoint	1	0	
Iredell	Crisis Recovery Center	1	1	
	UMAR-Weaver	1	1	
Lincoln	Brookwood Home	1	1	
Moore	Sandhills Center for MH/DD/SAS	1	0	
Nash	South Rocky Mount Home	1	0	
New Hanover	Robert E. Lee GH	2	0	
	New Hanover Treatment Center	2	0	
Onslow	White Oak GH II	1	1	
Pitt	Skill Creations of Greenville	1	0	
Richmond	Sandhills Center for MH/DD/SAS	1	0	
Wayne	White Oak Group Home II	1	1	1
Yadkin	Partnership for Behavioral Health	1	0	
Total		**22**	**7**	**1**

NOTES:

1. There were 3,333 Group Homes, Outpatient & Day Treatment Facilities with a total of 11,225 beds during the report period.

2. Shading in the last column, titled "# Investigated and Death was related to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not related to restraint or physical hold.

As noted in the preceding table, one death was related to restraint/hold. The facility was cited for non-compliance in ensuring one of six audited staff demonstrated competency in the use of restrictive interventions. The investigation was not able to establish a direct causal link between the client's death and the use of physical restraint by the facility staff. Other factors, such as the use of increasing amounts of psychotropic medications to moderate the client's behavior could not be eliminated as contributing to the client's death. Corrective action was taken and verified.

A number of private group homes, outpatient & day treatment facilities voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2005 and ending June 30, 2006, 11 facilities reported 13 such deaths. Each of these reports was screened, and eight reports were investigated. None of these deaths were related to restraint or hold. These numbers were not included in the above table.

Private Facilities: Intermediate Care Facilities for the Mentally Retarded (ICF-MR)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was related to Restraint/Hold[2]
Buncombe	Blue Ridge Homes-Swannanoa	1	1[3]	
Total		**1**	**1**	**0**

NOTES:

1. There were 332 Private ICF-MR's with a total of 2,667 beds during the report period.
2. Shading in the last column, titled "# Investigated and Death was related to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not related to restraint or physical hold.
3. The death occurred within 7 days of the use of physical restraint. The consumer had required seated restraint two days prior to death. However, the death was not related to the use of the restraint.

A few private ICF-MR's voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2005 and ending June 30, 2006, three facilities reported three such deaths. Each of these reports was screened, and one was investigated. None of these deaths were related to restraint or hold. These numbers were not included in the above table.

Private Facilities: Psychiatric Facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was related to Restraint/Hold[2]
Orange	UNC Hospitals	1	1	
Total		**1**	**1**	**0**

NOTES:

1. There were 6 Private Psychiatric Hospitals, 43 Hospitals with Acute Care Psychiatric Units, 7 Psychiatric Residential Treatment Facilities (PRTFs), 2 Wilderness Camps, and 9 Foster Care Camps with a total of 3,737 beds during the report period.
2. Shading in the last column, titled "# Investigated and Death was related to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not related to restraint or physical hold.

A few private psychiatric facilities voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2005 and ending June 30, 2006, two facilities reported two such deaths. Each of these reports was screened, and none were investigated. None of the deaths were related to restraint or hold. These numbers were not included in the

above table.

Private Facilities: Facilities not licensed in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5

County	Facility	# Deaths Reported and Screened	# Reports Investigated[1]	# Investigated and Death was related to Restraint/Hold[2]
Alleghany	New River Behavioral Healthcare	1	1	
Anson	FYW Homes	1	1	
Ashe	New River Behavioral Healthcare	1	1	
Beaufort	Tideland Mental Health/ Developmental Disabilities/ Substance Abuse Services	1	1	
Cabarrus	Consumer Planning and Support Services	1	1	
Carteret	LeChris Counseling	1	1	
Catawba	Catawba Valley Behavioral Healthcare	1	1	
Chatham	Caring Family Network	1	1	
	Orange-Person-Chatham Mental Health/Developmental Disabilities/ Substance Abuse Services	1	1	
Cleveland	Support, Inc.	1	1	
Cumberland	Cumberland Mental Health/ Developmental Disabilities/ Substance Abuse Services	2	2	
Dare	Albemarle Mental Health/ Developmental Disabilities/ Substance Abuse Services	1	1	
Davie	Hope Ridge	1	1	
	Triumph, LLC	1	1	
Durham	Area Services and Programs	2	2	
Forsyth	Triumph, LLC	1	1	
	Daymark Recovery Services	2	2	
Guilford	Family Services of the Piedmont	1	1	
	The Guilford Center	5	5	
Henderson	Mountain Laurel Community Services	1	1	
Moore	Sandhills Center for Mental Health/Developmental Disabilities/ Substance Abuse Services	1	1	
Orange	Family Counseling Center-OPC	1	1	
Pasquotank	Albemarle Mental Health/ Developmental Disabilities/ Substance Abuse Services	1	1	
Person	Person Counseling Center	1	1	
Randolph	Mental Health Association	1	1	
Richmond	Sandhills Center for Mental Health/Developmental Disabilities/ Substance Abuse Services	2	2	
Robeson	Coordinated Health Services	1	1	

Private Facilities: Facilities not licensed in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5 (Continued)

County	Facility	# Deaths Reported and Screened	# Reports Investigated[1]	# Investigated and Death was related to Restraint/Hold[2]
Rockingham	Rockingham Mental Health/ Developmental Disabilities/ Substance Abuse Services	2	2	
Rowan	Daymark Recovery Services	1	1	
Stanley	Daymark Recovery Services	2	2	
Surry	Triumph, LLC	1	1	
Transylvania	Mountain Laurel Community Services	1	1	
Wake	Area Services and Programs	1	1	
	Wake Human Services	4	4	
Wilkes	New River Behavioral Healthcare	1	1	
Yadkin	Insight Human Services	1	1	
Total		**49**	**49**	**0**

NOTES:

1. All of the deaths annotated in this column were investigated by the responsible Local Management Entity (LME) providing oversight, and the findings were reviewed by the Division of MH/DD/SAS.
2. Shading in the last column, titled "# Investigated and Death was related to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not related to restraint or physical hold.

A number of private facilities that were not licensed voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2005 and ending June 30, 2006, nine facilities reported nine such deaths. Each of these reports was screened and investigated by the responsible Local Management Entity providing oversight. None of the deaths were related to restraint or hold. These numbers were not included in the above table.

DEATHS REPORTED BY STATE FACILITIES

The last two tables provide data submitted by State facilities. It should be noted that death reporting for State facilities is different than for private facilities. The Secretary of DHHS has directed State-operated facilities to report all deaths to the Division of Facility Services, regardless of circumstance. This directive was first issued in April 2000 and re-issued in March 2001.

The following two tables for State facilities include all deaths, regardless of circumstances. For comparison with private facilities, summary information about the number of deaths that were subject to G.S. 122C-31 reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide) are provided below each table.

State Facilities: All Deaths Reported in State-Operated Intermediate Care Facilities for the Mentally Retarded (ICF-MR)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was related to Restraint/Hold[2]
Burke	J. Iverson Riddle Developmental Center	1	0	
Granville	Murdoch Center	8	5	
Lenoir	Caswell Center	15	0	
Wayne	O'Berry Center	6	0	
Total		**30**	**5**	**0**

NOTES:

1. There were 4 State-Operated ICF-MR's with a total of 2,470 beds during the report period.
2. Shading in the last column, titled "# Investigated and Death was related to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not related to restraint or physical hold.

The above table includes <u>all</u> deaths, regardless of circumstance. None of the deaths were related to restraint, physical hold, or seclusion. None of the above reported deaths were subject to G.S. 122C-31 reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide).

State Facilities: All Deaths Reported in State-Operated Psychiatric Hospitals and Alcohol and Drug Abuse Treatment Centers (ADATC)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was related to Restraint/Hold[2]
Burke	Broughton Hospital	8	4	
Granville	John Umstead Hospital	4	1	
Wake	Dorothea Dix Hospital	7	1	
Wayne	Cherry Hospital	7	3	1
Total		**26**	**9**	**1**

NOTES:

1. There were 4 State-Operated Psychiatric Hospitals with a total of 1,355 beds and 3 State-Operated Alcohol and Drug Abuse Treatment Centers with a total of 197 beds during the report period.
2. Shading in the last column, titled "# Investigated and Death was related to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not related to restraint or physical hold.

The preceding table includes <u>all</u> deaths, regardless of circumstance. Only one of the above reported deaths was subject to G.S. 122C-31 reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide). The remaining 25 deaths were due to other causes.

The one death subject to G.S. 122C-31 reporting requirements occurred at Cherry Hospital. Although not caused by the use of a physical restraint, the death was related to its use. A consumer was admitted on an emergency basis, given medication and restrained due to out of control behavior. The consumer died. The hospital was cited for failure to continuously monitor and evaluate the consumer while in restraint and failure to end the restraint as soon as possible

and was issued an Immediate Jeopardy. Corrective actions were taken, additional training was conducted, and follow-up monitoring was conducted to verify the corrective actions.

TOTAL DEATHS

In all, a total of 146 private facilities and eight State facilities reported 230 deaths for the time period beginning July 1, 2005 and ending June 30, 2006.

- A total of 174 deaths were reported by private facilities.

  Of this number, 110 were subject to statutory reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide).

  The other 64 were voluntarily reported. They were due to other causes and were not subject to statutory reporting requirements.

- A total of 56 deaths were reported by State facilities.

  Of this number, one was subject to statutory reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide).

  The other 55 were due to other causes and were not subject to statutory reporting requirements.

All deaths that were reported were screened. Over two-fifths (43.0%) of these deaths were investigated.

- One death occurred within seven days of restraint, physical hold, or seclusion. However, this death was not related to the use of restraint, physical hold, or seclusion.
- Two deaths were found to be related to the use of restraint, physical hold, or seclusion. The facilities involved were cited for non-compliances with rules, corrective actions were taken, and follow-up monitoring was conducted to verify corrective actions taken.

Blank copies of the death reports used by facilities are included as **Attachment A**: **Report of Deaths** (for licensed assisted living and psychiatric inpatient facilities) and **Attachment B: DHHS Incident and Death Report** (for all other facilities).

FACILITY COMPLIANCE WITH RESTRAINTS AND SECLUSION

Session Laws 2000-129 and 2003-80 also require the Department to report each year on facility compliance with restraint and seclusion policies. The data in this section were collected from on-site investigations, inspections and monitoring visits conducted by Department staff.

Separate tables are provided showing the number of restraint, physical hold, and seclusion related citations, by facility, for each type of facility, for the time period beginning July 1, 2005 and ending June 30, 2006. Additional data analysis is provided at the end of this section indicating the areas of highest and lowest non-compliance for each type of facility.

In reviewing the tables below, please note that the compliance data do not reflect all facilities. Rather, the data are limited to those facilities that warranted an on-site visit by Department staff. These visits include initial and change-of-ownership licensure surveys, reviews of problem-prone facilities, deficiency follow-up visits, and complaint and death investigations. If a facility

is not listed in the following tables, a citation for non-compliance with restraint/seclusion rules was not made.

NUMBER OF RESTRAINT/SECLUSION RELATED CITATIONS

Private Facilities: Licensed Assisted Living Facilities

County	Facility	# Citations
Alexander	Shady Rest	2
Buncombe	Canterbury Hills	3
	Marjorie McCune Memorial Center	2
Caldwell	Camelot Manor DBA Brockford Inn	2
Cumberland	Forest Hills Rest Home	1
Catawba	Country Manor	2
Duplin	Golden Care	1
Durham	Eno Pointe Assisted Living	2
	Meadows of Oak Grove	1
Haywood	McCracken Rest Home	2
Hertford	Pinewood Manor	2
	Twin Oaks Rest Home	1
Hoke	Open Arms Retirement Center	2
Mecklenburg	Haven in the Village	2
Moore	Tara Plantation	2
Robeson	St. Mary's Assisted Living	2
Rutherford	Restwell Home	1
Wake	Aversboro Assisted Living	1
	Sunrise Assisted Living	5
Wilson	Elm City Assisted Living	2
Total		**38**

Private Facilities: Group Homes, Outpatient and Day Treatment Facilities

County	Facility	# Citations
Alamance	Everlasting Care Center	2
	Angels DDA Care Center	1
Bertie	Emma's Hope	1
Burke	Kela Drive Home	2
Catawba	Houston & Odom	2
Cherokee	Advantage Enrichment Center	2
Clay	Hayesville Group Home	2
Cleveland	Uniquely Supported #1	1
	Uniquely Supported #5	1
	Uniquely Supported #6	1
	Uniquely Supported #8	1
	Uniquely Supported #9	1
	Uniquely Supported #11	1
	Uniquely Supported #12	2
	Uniquely Supported #13A	1
	VOCA-Roxford	1
	Changing Lifestyles RTC	1
Columbus	Murchison House	1
Cumberland	Wings of Angels	2

Private Facilities: Group Homes, Outpatient and Day Treatment Facilities (Continued)

County	Facility	# Citations
	Magby #6	1
	Woodbridge at Cadmium	1
	Changing Lifestyles	1
	New Directions	1
	Sunrise Group Home	1
	Manchester Home	1
	Alpha House I	1
	Changing Lifestyles RTC	2
Davidson	ODAAT	1
Duplin	Johnson House	1
Forsyth	Park field	1
Guilford	Brightwood Group Home	1
	Genesis Professionals	2
	Hunter's Run	1
Henderson	Lighthouse- Little Light Ministries	2
Iredell	Crisis Recovery Center	1
Jackson	South Painter/Cullowhee Group Home	2
Lenoir	Nova	2
Lincoln	ALF	2
	A Chance for Hope Residential	2
Mecklenburg	Christian Focus Center	1
	Little Light Ministries	2
	Blair Road Group Home	1
	Turn Around	2
	New Place	2
	Universal Psychiatry	2
Nash	Impact One	1
New Hanover	Yahweh Center	1
Polk	Cooperrilis	1
Rowan	Quality Care Developmental Services	3
Rutherford	Chrisman Home	1
Surry	Maple Street Home	1
	Hodges Valley Group Home	2
Vance	Charles Street Facility	2
	Gillberg Facility	2
Wake	Serenity Place II	1
Wilkes	Synergy Recovery	1
Wilson	Youth Services III	3
Total		**82**

Private Facilities: Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

County	Facility	# Citations
Lee	T.L.C. Home	1
Mecklenburg	RHA/Howell's Child Care Center/Lakeview	1
Total		**2**

Private Facilities: Psychiatric Facilities (Except PRTFs)

County	Facility	# Citations
New Hanover	Cape Fear Valley Hospital	1
Mecklenburg	Presbyterian Hospital/Charlotte	1
Total		2

Private Facilities: Psychiatric Residential Treatment Facilities (PRTFs)

County	Facility	# Citations
Onslow	Brynn Marr	1
Mecklenburg	Alexander Children's Home	1
Total		2

Psychiatric Residential Treatment Facilities (PRTFs) are a special category of facilities that are subject to more stringent federal standards governing the use of restrictive interventions. The above table reflects the number of citations that were issued to these facilities by both state and federal reviewers for non-compliance with restraint and seclusion requirements.

Private Facilities: Facilities not licensed in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5

County	Facility	# Citations
	No restraint/seclusion related citations were issued	0
Total		0

State Facilities: State-Operated Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

County	Facility	# Citations
	No restraint/seclusion related citations were issued	0
Total		0

State Facilities: State-Operated Psychiatric Hospitals and Alcohol and Drug Abuse Treatment Centers (ADATC)

County	Facility	# Citations
Burke	Broughton Hospital	1
Wayne	Cherry Hospital	2
Total		3

For all facility types, a total of 83 private facilities and two State-operated facilities were issued a total of 129 citations for non-compliance with restraint/seclusion regulations for the time period beginning July 1, 2005 and ending June 30, 2006.

MOST AND LEAST FREQUENT AREAS OF RESTRAINT/SECLUSION NON-COMPLIANCE

The following table provides an analysis of the most and least frequent areas of restraint/ seclusion non-compliance. Percentages represent the percentage of all citations for that type of facility.

Caution should be exercised when comparing percentages across different facility types. The total number of citations upon which the percentages for each facility type are based can vary widely and could result in the differences in the percentages being misinterpreted if not careful. For example, in the case of Private ICF-MRs where a total of two (2) citations were issued, **a single citation** would equate to **50%** of the total. In contrast, in the case of Private Group Homes, Outpatient and Day Treatment Facilities where 82 citations were issued, **a single citation** would equate to **1%** of the total. In this example, a single citation would produce very different percentages for the two facility types. To make it easier to interpret the percentages, the table provides the number of citations and total citations upon which the percentages are based.

Facility Type	Areas of Restraint/Seclusion Non-Compliance	
	Most Frequent	**Least Frequent**
Private Licensed Assisted Living Facilities (38 citations)	• Inappropriate use of restraints (14 citations = 37%) • Inadequate assessment and care planning (9 citations = 24%) • Inadequate restraint orders (8 citations = 21%)	• Inadequate documentation of restraint use (2 citations = 5%)
Private Group Homes, Outpatient and Day Treatment Facilities (82 citations)	• Failure to receive training in restrictive interventions (26 citations = 32%) • Failure to receive training in alternatives to restrictive intervention (21 citations = 26%) • Improper restraint resulted in harm (9 citations = 11%) • Utilized improper technique during restraint (7 citations = 9%)	• Failed to use least restrictive alternative prior to restraint (1 citation = 1%) • No policy for least restrictive alternative (1 citation = 1%) • Improper restraint (1 citation = 1%) • Failed to document restraint (1 citation = 1%) • Insufficient training procedures (1 citation = 1%)
Private ICF-MRs (2 citations)	• Failure to document or inadequate documentation on the use of restraints (2 citations = 100%)	• **None in this category** (Both citations were listed in the most frequent column)
Private Psychiatric Facilities (Except PRTFs) (2 citations)	• **None in this category** (None of the citations that were issued were listed more than once)	• Inadequate assessment and care planning (1 citation = 50%) • Failure to end restraint as soon as possible (1 citation = 50%)

Facility Type	Areas of Restraint/Seclusion Non-Compliance (Continued)	
	Most Frequent	Least Frequent
Private Psychiatric Residential Treatment Facilities (PRTFs) (2 citations)	• **None in this category** (None of the citations that were issued were listed more than once)	• Failure to secure initial MD order (1 citation = 50%) • Inappropriate use of restraint procedures (1 citation = 50%)
State Psychiatric Hospitals and ADATCs (3 citations)	• **None in this category** (None of the citations that were issued were listed more than once)	• Inadequate policies and procedures (1 citation = 33%) • Failure to continuously monitor and evaluate during restraint (1 citation = 33%) • Failure to end restraint as soon as possible (1 citation = 33%)

SUMMARY

Deaths. In all, a total of 146 private facilities (101 licensed and 45 unlicensed facilities) and eight State facilities reported 230 deaths for the time period beginning July 1, 2005 and ending June 30, 2006. This represents 2.0% of the 5,030 licensed private facilities and 100% of the eight State facilities reported one or more deaths.

- A total of 174 deaths were reported by private facilities. Of this number, 110 deaths were subject to statutory reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide). The other 64 deaths were voluntarily reported. They were due to other causes and were not subject to statutory reporting requirements.
- A total of 56 deaths were reported by State facilities. Of this number, one was subject to statutory reporting requirements, and 55 were not subject to statutory reporting requirements.

All deaths that were reported were screened. Over two-fifths (43.0%) of these deaths were investigated.

- One death occurred within seven days of restraint, physical hold, or seclusion. However, this death was not related to the use of restraint, physical hold, or seclusion.
- Two deaths were found to be related to the use of restraint, physical hold, or seclusion. The facilities involved were cited for non-compliances with rules, corrective actions were taken, and follow-up monitoring was conducted to verify corrective actions taken.

Restraint/Seclusion Rules Compliance. In all, a total of 83 licensed private facilities and two State-operated facilities were cited for non-compliance with one or more restraint/seclusion rules during this same time period. Approximately two percent (1.7%) of the 5,030 licensed private facilities and 25% of the eight State-operated facilities received a citation.

However, it should be noted that the compliance data do not reflect all facilities. Rather, the data are limited to those facilities that warranted an on-site visit by Department staff. These visits included initial, renewal and change-of-ownership licensure surveys, deficiency follow-up visits,

and complaint and death investigations. A total of 1,196 licensure surveys, 745 deficiency follow-up visits, and 960 complaint and death investigations were conducted. Because of possible overlaps in the number of facilities reviewed for the different types of reviews, an exact unduplicated count of facilities reviewed is not available. A conservative approximation would be that under four percent (3.9%) of the estimated 2,150 licensed facilities that were reviewed were issued a citation related to restraint/seclusion.

No unlicensed facilities were cited for non-compliance with restraint/seclusion rules. A total of 72 complaint investigations involving unlicensed facilities were conducted during this period. None of these investigations identified non-compliances related to the use of restraint/seclusion, and no citations related to the use of restraint/seclusion were issued.

A total of 129 citations were issued for non-compliance with restraint/seclusion rules across all facility types. For those facilities that were cited for non-compliance, citations covered a wide range of areas from inadequate documentation and training to improper or inappropriate use of restraint. The largest number of citations issued regardless of facility type involved failure to receive training in restrictive interventions (20%), failure to receive training in alternatives to restrictive interventions (17%), inappropriate use of restraints (11%), and improper restraint (8%). These citations accounted for 56% of the total issued.

Attachment A

REPORT OF DEATH TO DHHS

All requested information must be provided. This form is for reporting resident deaths for all facilities operating under G.S. 131D-2. A resident's death occurring within seven days of physical restraint or physical hold of the resident, including death occurring within 24 hours of transfer to a hospital, must be reported immediately. All resident deaths resulting from accident, homicide, suicide or violence must be reported within three days of the death. If any requested information is unavailable, provide an explanation. The information must be provided immediately upon its availability. ■ *If additional space is needed,* attach separate sheets, referencing the part of the form to which the information pertains. ■ You may include additional information that you consider helpful, such as resident assessments and discharge summaries. ■ **(Please Note: Facilities are encouraged to keep a copy of the report for their records)**

***Submit form to*: Complaint Intake Unit, 2711 Mail Service Center., Raleigh, NC 27699. Fax: (919) 715-7724; Phone: (919) 733-8499.**

Section I: Reporting Facility

Name of reporting facility:	Medicare/Medicaid Provider # (if applicable):	Facility director:	Telephone:
Address:	License # :	First person to discover decedent:	Staff first receiving report of decedent's death:
	County:	Person (including title) preparing report:	Date/Time report prepared:

Section 2: Resident Information

Name of decedent:	Resident Record # (if applicable):	Unit/Ward (if applicable):	
	Medicare/Medicaid No (if applicable):	Date of Birth:	Age:
Admitting diagnoses:	Adjudicated incompetent: ☐ Yes ☐ No	Weight (if known):	Race:
	Date(s) of last two (2) medical exams (if known):	Height (if known):	Sex:

Date of most recent admission to a State operated psychiatric, developmental disability or substance abuse facility (if known):	Date of most recent admission to an acute care hospital for physical illness (if known):
Primary/secondary mental illness, developmental disability, or substance abuse diagnosis (if applicable):	Primary/secondary physical illness/conditions diagnosed prior to death:

Section 3: Circumstances of Death

Place where decedent died:	Date and time death was discovered:	
Address:	Physical location decedent was found:	
	Cause of death (if known):	

Was decedent "restrained" at the time of death or within 7 days of death including a death that occurred within 24 hours of transfer or discharge to a hospital?

☐ Yes ☐ No If "yes," describe type and usage:

Describe events surrounding the death:

Section 4: Other Information

Please list other authorities (such as law enforcement or the County Department of Social Services) that have been notified, have investigated or are in the process of investigating the death or events related to the death:

Attachment B

North Carolina Department of Health & Human Services – Division of Mental Health/Developmental Disabilities/Substance Abuse Services

CONFIDENTIAL **DHHS Incident and Death Report** *CONFIDENTIAL*

Provider Agency Name _____ Consumer's Name _____ LME Client Record Number. _____

This form is used to report Level II and Level III incidents, including deaths and restrictive interventions, involving any person receiving publicly funded mental health, developmental disabilities and/or substance abuse (MH/DD/SA) services. Facilities licensed under G.S. 122C (except hospitals) and unlicensed providers of community-based MH/DD/SA services must submit the form, as required by North Carolina Administrative Code 10A NCAC 27G .0600, 26C .0300, and 27E .0104(e)(18). Failure to complete this form may result in administrative actions against the provider's license and/or authorization to receive public funding. This form may also be used for internal documentation of Level I incidents, if required by provider policy or LME contract. **Effective March 8, 2006, this form replaces the *DHHS Incident and Death Report (Form QM02, Revised 11/18/04).***

***Instructions:* Complete and submit this form to the local and/or state agencies responsible for oversight within 72 hours of learning of the incident (See page 3 for details). Report deaths of consumers that occur within 7 days of restraint or seclusion immediately.**
If requested information is unavailable, provide an explanation on the form and report the additional information as soon as possible.
***Page 1-2 Instructions:* The staff person who is most knowledgeable about the incident should complete pages 1-2 of this form as soon as possible after learning of the incident and submit to the unit supervisor for review and approval.**

Date of Incident: _____ **Time of Incident:** _____ ☐ a.m. ☐ p.m. ☐ Unknown

CONSUMER INFORMATION

Consumer's Date of Birth: _____ **Consumer's Gender:** ☐ Male ☐ Female

All Diagnoses: _____ **Consumer's Ethnicity** (*Check all that apply*):

☐ Hispanic/Latino ☐ Native American ☐ Asian/Pacific Islander
☐ White/Anglo ☐ Black/African American ☐ Other (*specify*): _____

Does consumer receive CAP/MR-DD Waiver services? ☐ Yes ☐ No ☐ Unknown

DESCRIPTION OF INCIDENT

LOCATION OF INCIDENT

☐ Provider premises
☐ Consumer's legal residence
☐ Community
☐ Other (*specify*) _____
(such as hospital, state institution, etc.)
☐ Unknown

OTHER PEOPLE INVOLVED

(Provide the name of the person and his/her relationship to the consumer that is the subject of the report. Do not provide the name or other identifying information for other consumers in this section. Instead indicate the number of other consumers who were involved.)

	Other Consumer	Staff	Other
1.	☐	☐	☐
2.	☐	☐	☐
3.	☐	☐	☐
4.	☐	☐	☐
5.	☐	☐	☐

Name / title of first staff person to learn of incident _____

Was the consumer under the care of the reporting provider at the time of the incident? ☐ Yes ☐ No

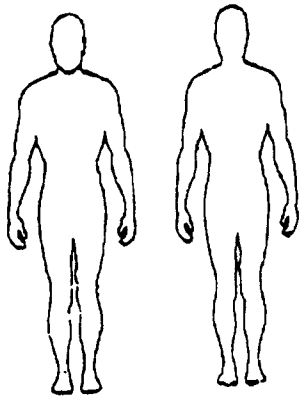
Was the consumer treated by a licensed health care professional for the incident? ☐ Yes ☐ No Date: _____

Was the consumer hospitalized for the incident? ☐ Yes ☐ No Date: _____

Describe the incident, including Who, What, When, Where, and How. *(Describe any preceding circumstances, resulting harm to people, property damage, and any other relevant information. Attach additional pages if needed. Do not provide another consumer's name or identifying information here.)*

INJURY

On the figures below, circle the location of any bruises, cuts, scratches, injuries, or other marks that occurred as a result of the incident.



FRONT BACK

NOTE: Incident reports are confidential quality assurance documents, protected by GS 122C-30, 122C-31, 122C-191 and 122C-192. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164.

CONFIDENTIAL

DHHS Incident and Death Report

CONFIDENTIAL

Provider Agency Name | Consumer's Name | LME Client Record Number.

TYPE OF INCIDENT

CONSUMER DEATH

Death due to: ☐ SUICIDE ☐ ACCIDENT ☐ HOMICIDE / VIOLENCE ☐ Terminal illness / natural cause ☐ Unknown cause

Did death occur within 7 days of the restrictive intervention? ☐ Yes ☐ No *If yes, immediately submit this form to your supervisor.*

DETAILS OF DEATH REPORTABLE TO NC DEPARTMENT OF HEALTH & HUMAN SERVICES

Complete this section only for deaths from suicide, accident, or homicide/violence or occurring within 7 days of restrictive intervention.

Address where consumer died: _____

Physical illnesses / conditions diagnosed prior to death: _____

Dates of last two (2) medical exams: _____ _____ ☐ Unknown ☐ None

Date of most recent admission to a hospital for physical illness: _____ ☐ Unknown ☐ None

Date of most recent admission to an inpatient MH/DD/SAS facility: _____ ☐ Unknown ☐ None

Height: ____ ft ____ in ☐ Unknown **Weight:** _____ lbs ☐ Unknown **Adjudicated incompetent?** ☐ Yes ☐ No

RESTRICTIVE INTERVENTION

(Number in order of use)

____ Physical Restraint

____ Isolation

____ Seclusion

Is the use of restrictive intervention part of the consumer's Individual Service Plan? ☐ Yes ☐ No

Was the restrictive intervention administered appropriately? ☐ Yes ☐ No

Did the use of restrictive intervention(s) result in discomfort, complaint, or require treatment by a licensed health professional? ☐ Yes ☐ No

Attach a Restrictive Intervention Details Report (Form QM03) or a provider agency form with comparable information.

OTHER INCIDENT

INJURY

Report injuries requiring treatment by a licensed health professional

(Check only one)

Injury due to:

☐ Aggressive behavior

☐ Self-injury/mutilation

☐ Trip or fall

☐ Auto accident

☐ Other (specify) _____

ABUSE ALLEGATION

(Check all that apply)

☐ Alleged abuse of a consumer

☐ Alleged neglect of a consumer

☐ Alleged exploitation of a consumer

Report any alleged or suspected case of abuse, neglect or exploitation of a consumer, as required by law, to the county Dept. of Social Services and the DFS Healthcare Personnel Registry, as well as the host LME.

MEDICATION ERROR

Report errors that threaten health or safety

(Check only one)

☐ Wrong dosage administered

☐ Wrong medication administered

☐ Wrong time *(administered more than one hour from prescribed time)*

☐ Missed dosage *(including refusals)*

CONSUMER BEHAVIOR

(Check only one)

☐ Suicide attempt

Report the following whenever a report to legal authorities is made:

☐ Inappropriate or illegal sexual behavior

☐ Illegal acts by a consumer

☐ Other consumer behavior

OTHER INCIDENT

(Check only one)

☐ Suspension of a consumer from services [*Enter number of days* ____]

☐ Expulsion of a consumer from services

☐ Fire that threatens or impairs a consumer's health or safety

☐ Unplanned consumer absence more than 3 hours over time allowed in the Person Centered Plan or service plan *(where absence is restricted by the plan)* or absence reported to legal authorities

Name/title of staff person documenting incident *(Please print)*:

_____ Phone (____) _____

Signature _____ Date _____ Time _____ ☐ a.m. ☐ p.m.

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CONFIDENTIAL **DHHS Incident and Death Report** *CONFIDENTIAL*

Provider Agency Name _____ Consumer's Name _____ LME Client Record Number. _____

***Page 3 Instructions:** The supervisor of the service should review pages 1-2 of this form, complete page 3 and submit to required agencies in the required timeframes. Use Criteria on page 5 to determine the level of incident. Refer to the Incident Response Manual for further details.*

PROVIDER INFORMATION

Facility / Unit _____ Facility /Unit Director: _____

Service address: _____ City: _____ County _____

Facility /Unit Phone Number: (___) _____ Provider Tax ID or Social Security No.: _____

Service being provided at time of incident: ☐ Residential ☐ Non-residential *(specify)* _____ ☐ N/A

122C-Licensed service? ☐ No ☐ Yes *(License No.)* _____ ***If yes, note reporting instructions for Level III below.***

LEVEL OF INCIDENT

☐ **Level II (Moderate)**

Send this form to the host LME (LME responsible for geographic area where service is provided) within 72 hours. If required by contract, also report to the consumer's home LME if different.

☐ **Level III (High)**

Immediately report verbally to the host LME. Convene an incident review committee within 24 hours if services were being actively provided at time of incident. (See manual for details.) Send this form within 72 hours to:

- *host LME (see bottom of page)*
- *consumer's home LME*
- *NC Division of MH/DD/SAS, Quality Management Team, 3004 MSC, Raleigh, NC 27699-3004. Voice: (919) 733-0696, Fax: (919) 715-3604*

NOTE: *Report deaths that occur within 7 days of seclusion or restraint immediately.*

NOTE: *If the service is licensed under G.S.122C, also use the same deadlines to report death from suicide, accident, or homicide/violence and deaths occurring within 7 days of restraint or seclusion, to the NC Division of Facility Services, Complaint Intake Unit, 2711 MSC, Raleigh, NC 27699-2711 Voice: 1-800-624-3004 Fax: 1-919-715-7724*

PROVIDER RESPONSE

Describe the cause of the incident ***(attach additional pages if needed)*:**

Describe how this type of incident may be prevented in the future and any corrective measures that have been or will be put in place as a result of the incident ***(attach additional pages if needed)*:**

REPORTING INFORMATION

Indicate authorities or persons notified of the incident ***(as applicable)*:**

Agency / Person	Contact Name	Phone	Notification Date
☐ Host LME _____		(___)	
☐ Home LME _____		(___)	
☐ Law enforcement		(___)	
☐ County DSS _____		(___)	
☐ Health Care Personnel Registry		(___)	
☐ Service Plan Team		(___)	
☐ Parent / Guardian		(___)	
☐ NC DMH/DD/SAS		(___)	
☐ NC DFS Complaint Unit		(___)	
☐ Other _____		(___)	

Name/title of supervisor authorizing report *(Please print)*:

_____ Phone (___) _____

Signature _____ Date _____ Time _____ ☐ a.m. ☐ p.m.

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CONFIDENTIAL **DHHS Incident and Death Report** *CONFIDENTIAL*

Provider Agency Name | Consumer's Name | LME Client Record Number.

Page 4 Instructions: *This page is available for the provider agency or any agencies receiving the report to use for internal tracking and follow-up purposes. Leave this page blank when sending an incident report to the LME and/or other agencies..*

INCIDENT TRACKING *(for internal use only)*

INTERNAL USE ONLY

Incident Report Receipt Date: _____

Current Consumer Status:

LME's (or Other Oversight Agency's) Response:

Name/title of follow-up staff person *(Please print)*:

_____ Phone (____) _____

Signature _____ Date _____ Time _____ ☐ a.m. ☐ p.m.

INTERNAL USE ONLY

Notes:

NOTE: Incident reports are confidential quality assurance documents, protected by GS 122C-30, 122C-31, 122C-191 and 122C-192. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164.

DHHS Criteria for Determining Level of Response to Incidents

Incidents are events that are inconsistent with the routine operation of a service or care of a consumer that are likely to lead to adverse effects. Providers must report incidents, as defined below, that occur while a consumer is under their care. Individuals receiving residential and ACT Team services are considered under the provider's care 24 hours a day. Individuals receiving day services and periodic services are considered under the provider's care while a staff person is actively engaged in providing a service. See Manual for details.

	EVENT	LEVEL I	LEVEL II	LEVEL III[1]	EXCEPTIONS
CONSUMER DEATH	Consumer Death	----------	Due to: - Terminal illness or other natural cause - Unknown cause	Due to: - Suicide - Violence / homicide - Accident Or occurring: - Within 7 days of seclusion or restraint	• Providers of non-residential services should report as soon as they learn of death. • Review of Level III incidents within 24 hours needed only if actively engaged in providing service at time of death.
RESTRICTIVE INTERVENTION	Seclusion Isolated time-out Restraint	Any planned use administered appropriately and without discomfort, complaint, or injury[2]	1. Any emergency, unplanned use OR 2. Any planned use that exceeds authorized limits, is administered by an unauthorized person, results in discomfort or complaint, or requires treatment by a licensed health professional	Any restrictive intervention that results in permanent physical or psychological impairment within 7 days	Providers will submit aggregate numbers of Level I restrictive interventions to the host LME quarterly.[2]
CONSUMER INJURY	Due to: - Aggressive behavior - Self-injury/mutilation - Trip or fall - Auto accident - Other / unknown cause	Any injury that requires only first aid, as defined by OSHA guidelines[2] *(regardless of who provides the treatment)*	Any injury that requires treatment by a licensed health professional *(such as MD, RN, or LPN)* beyond first aid, as defined by OSHA guidelines[2]	Any injury that results in permanent physical or psychological impairment and any allegation of rape or sexual assault by someone other than a staff member or caregiver	Providers of non-residential services should report Level II incidents only if actively engaged in providing service at time of incident
ABUSE	Abuse of consumer Neglect of consumer Exploitation of consumer	----------	Any allegation of abuse, neglect or exploitation of consumer by staff or other adult, including inappropriate touching or sexual behavior	Any allegation of abuse, neglect or exploitation of consumer that results in permanent physical or psychological impairment, arrest, or involves an allegation of rape or sexual assault by a staff member or caregiver	• Providers of non-residential services should report as soon as they learn of allegation. • Review of Level III incidents within 24 hours needed only if actively engaged in providing service at time of alleged incident.
MED ERROR	Wrong dose Wrong medication Wrong time (over 1 hour from prescribed time) Missed dose or medication refusal	Any error that does not threaten the consumer's health or safety *(as determined by the physician or pharmacist notified of the error)*	Any error that threatens the consumer's health or safety *(as determined by the physician or pharmacist notified of the error)*	Any error that results in permanent physical or psychological impairment	• Providers of periodic services should report errors for consumers who self-administer medications as soon as learning of the incident. • Review of Level III incidents within 24 hours needed only if actively providing service at time of incident. • All providers will submit aggregate numbers of Level I medication errors to the host LME quarterly.[2]
		NOTE: Report all drug administration errors and adverse drug reactions to a physician or pharmacist immediately, as required by 10A NCAC 27G .0209(h).			

[1] Providers should notify the host and home LMEs by phone upon learning of any Level III incident, even if not actively providing service at the time of the incident.

[2] See Manual for details.

NOTE: Incident reports are quality assurance documents. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected. Use the form according to confidentiality requirements in NC General Statutes and Administrative Code and the Code of Federal Regulations.

DHHS Criteria for Determining Level of Response to Incidents

	EVENT	LEVEL I	LEVEL II	LEVEL III[1]	EXCEPTIONS
CONSUMER BEHAVIOR	Suicidal behavior	Any suicidal threat or verbalization that indicates new, different or increased behavior	Any suicide attempt	Any suicide attempt that results in permanent physical or psychological impairment	Do not report previous suicide attempts by persons seeking services through the LME Access unit or for whom inpatient commitment is being sought.
	Sexual behavior	Inappropriate sexual behavior that does not involve a report to law enforcement or complaint to an oversight agency	Any sexual behavior that involves a report to law enforcement, a complaint to an oversight agency, or a potentially serious threat to the health or safety of self or others	Any sexual behavior that results in death, permanent physical or psychological impairment, arrest of the consumer, or public scrutiny *(as determined by the host LME)*	----------
	Consumer act	Any aggressive or destructive act that does not involve a report to law enforcement or complaint to an oversight agency	Any aggressive or destructive act that involves a report to law enforcement, a complaint to an oversight agency, or a potentially serious threat to the health or safety of self or others	Any aggressive or destructive act reported to law enforcement or an oversight agency that results in death, permanent physical or psychological impairment, or public scrutiny *(as determined by the host LME)*	----------
	Consumer absence	Any absence of 0 to 3 hours over the time specified in the service plan, if police contact is not required	Any absence greater than 3 hours over the time specified in the individual's service plan or any absence that requires police contact	----------	Report absences of competent adult consumers receiving non-residential services <u>only</u> if police contact is required.
OTHER	Suspension from services Expulsion from services	Any provider withdrawal of services for less than one day for consumer misconduct	Any provider withdrawal of services for one day or more for consumer misconduct	----------	----------
	Fire	Any fire with no threat to the health or safety of consumers or others	Any fires that threatens the health or safety of consumers or others	Any fire that results in permanent physical or psychological impairment or public scrutiny *(as determined by the host LME)*	----------
	Search and seizure	Any	----------	----------	All providers will submit aggregate numbers of searches and seizures to the host LME quarterly.[2]
	Confidentiality breach	Any	----------	----------	----------

<u>Direct questions to:</u> *ContactDMHQuality@ncmail.net Phone: (919) 733-0696*

[1] Providers should notify the host and home LMEs by phone upon learning of any Level III incident, even if not actively providing service at the time of the incident.

[2] See Manual for details.

<u>NOTE</u>: Incident reports are quality assurance documents. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected. Use the form according to confidentiality requirements in NC General Statutes and Administrative Code and the Code of Federal Regulations.